Supreme Court, U.S.
FILED
MAY 27 1998
OFFICE OF THE CLERK

No. 97-1630

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

LAURA MELENDEZ,

Petitioner,

—v.—

METROPOLITAN LIFE INSURANCE CO.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Allan M. Marcus*
Marilyn M. Cochran
One Madison Avenue
New York, New York 10010
(212) 578-4956

Robert J. Fuller
329 Brooks Lane
Coppell, Texas 75019
(972) 393-5878

Attorneys for Respondent

** Counsel of Record*

32 pp

PARTIES TO THE PROCEEDING

The caption correctly lists the parties to the proceeding. Respondent Metropolitan Life Insurance Company ("MetLife"), a mutual life insurance company, has no parent or subsidiaries that have issued shares to the public. The only affiliates of which MetLife has actual ownership (for its own account) which have issued shares to the public are: (1) Chart House Enterprises, Inc., in which MetLife owns 12.65% of issued, voting shares; (2) Lone Star Industries, Inc., in which MetLife owns 13.47% of issued, voting shares; (3) New England Investment Companies, L.P., in which MetLife owns 48.64% of issued, voting shares; and (4) Dan River, Inc., in which MetLife owns 26% of issued, voting shares.

TABLE OF CONTENTS

PAGE

PARTIES TO THE PROCEEDING i

TABLE OF CONTENTS ii

TABLE OF AUTHORITIES iii

STATEMENT OF THE CASE 1

Procedural History 1

Factual Background 3

REASONS FOR DENYING THE WRIT 8

I. The Rule Proposed By Petitioner Would Not Change the Outcome In This Case 8

A. The Circuits Use a Fact-Specific Approach to Determine the Effect of a Conflict of Interest 9

B. Undisputed Facts Support the Judgment in this Case Regardless of How the Burden of Proof is Allocated 12

II. The Decision in this Case is Consistent with Public Policy Underlying ERISA 15

CONCLUSION 17

TABLE OF AUTHORITIES

Cases PAGE

Anderson v. Liberty Lobby, Inc., 477 U.S. 242 (1986) 13, 14

Bedrick v. Travelers Ins. Co., 93 F.3d 149 (4th Cir. 1996) 10, 13

Brown v. Blue Cross & Blue Shield, 898 F.2d 1556 (11th Cir. 1990), *cert. denied*, 498 U.S. 1440 (1991) 9, 10, 13

Chalmers v. Quaker Oats Co., 61 F.3d 1340 (7th Cir. 1995) 15

Chambers v. Family Health Plan, 100 F.3d 818 (10th Cir. 1996) 10, 11

Childs v. National Bank of Austin, 658 F.2d 487 (7th Cir. 1981) 16

Clements v. Nassau County, 835 F.2d 1000 (2d Cir. 1987) 14

DeFelice v. American Ins. Co., 112 F.3d 59 (2d Cir. 1997) 3

Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228 (4th Cir. 1997) 11

Firestone Tire & Rubber v. Bruch, 489 U.S. 101 (1989) 8

Guillory v. Domtar Industries, Inc., 95 F.3d 1320 (5th Cir. 1996) 14

Kennedy v. Blue Cross and Blue Shield, 989 F.2d 588 (2d Cir. 1993) 5

Lang v. Long Term Disability Plan, 125 F.3d 794 (9th Cir. 1997) 10, 13

PAGE

Meister v. Georgia Pacific Corp., 43 F.3d 1154 (7th Cir. 1995) 14

Pagan v. NYNEX Pension Plan, 52 F.3d 438 (2d Cir. 1995) 11, 12

Semmler v. Metropolitan Life Ins. Co., 172 F.R.D. 86 (S.D.N.Y. 1997) 2, 5, 7, 12, 13

Semmler v. Metropolitan Life Ins. Co., 1995 WL 559390 (S.D.N.Y.) 1, 2, 7, 11

Semmler v. Metropolitan Life Ins. Co., 1998 WL 4069 (2d Cir.) 3

Semtner v. Group Health Services of Oklahoma, Inc., 129 F.3d 1390 (10th Cir. 1997) 11

Sullivan v LTV Aerospace & Defense Co., 82 F.2d 1251 (2d Cir. 1996) 2, 11, 12

Statutes

29 U.S.C. § 1108(c)(3) 16

Rules

Fed. R. Civ. P. 56(e) 12

Fed. R. Civ. P. 60(b) 2

Sup. Ct. R. 10 ..... 9, 17

Other Authorities

HCFA Directive, 3 *Medicare Report* 906, 913 (BNA, July 24, 1992) 11

Restatement (Second) of Trusts, Sec. 187, cmt. d (1959) 8

STATEMENT OF THE CASE

The arguments in both the District Court and the Second Circuit focused on whether it was reasonable for respondent Metropolitan Life Insurance Company ("MetLife"), an ERISA claims administrator exercising its discretion, to decide that it should pay only one doctor, rather than two doctors, to write a single prescription and make rounds to monitor petitioner's pain medication following surgery. As detailed below, petitioner's surgeon billed and was paid a "package" fee which included compensation for these services. MetLife's rejection of duplicative bills from petitioner's anesthesiologist for the same services gave rise to the parties' dispute. MetLife's determination has been reviewed and found reasonable three times in this case—by two different District Judges and by the Second Circuit.

Petitioner now seeks review of an issue which was not raised in the District Court, which was raised only in cursory fashion before the Second Circuit, and which could not have altered the outcome in either court. That issue is who bears the burden of proving that a conflict of interest did (or did not) influence the benefit determination. The District Court found that uncontradicted evidence *affirmatively* established that MetLife's benefit determination was *not* influenced by a conflict of interest. That finding supports the judgment for MetLife regardless of whether MetLife or petitioner has the burden of proof on that issue. Review by this Court would be pointless because the sole issue presented here cannot change the outcome of this case.

Procedural History

The reasonableness of MetLife's rejection of duplicative benefits for post-operative pain services was first presented to Senior District Judge Whitman Knapp. No issue with respect to conflict of interest was raised at that time. In his September 15, 1995 Opinion, Judge Knapp found that MetLife's determination was not arbitrary and capricious, and granted summary judgment dismissing petitioner's claim. *Semmler v. Metropolitan*

Life Ins. Co., 1995 WL 559390 (S.D.N.Y.) (reprinted in Petitioner's Appendix (hereafter "App.") at A-1).

After this case was reassigned to District Judge Sonia Sotomayor, petitioner requested and was given leave under Fed. R. Civ. P. 60(b) to seek reconsideration of Judge Knapp's judgment in light of the intervening decision of the Second Circuit in *Sullivan v LTV Aerospace & Defense Co.*, 82 F.2d 1251 (2d Cir. 1996), which set out analytical steps for determining the impact of a conflict of interest on the standard of review under ERISA. Petitioner raised the conflict of interest issue for the first time in her Rule 60(b) motion. Ironically, *Sullivan*—which petitioner now asks this Court to overrule—is the very precedent which petitioner used to obtain leave to file her Rule 60(b) motion. Petitioner relied heavily on *Sullivan* in arguing her motion to the District Court, and in no wayquestioned the holding in *Sullivan* that the claimant bears the burden of proving that the benefit determination was influenced by a conflict of interest. Accordingly, the District Court did what both parties urged, i.e., applied the *Sullivan* analysis to the facts established by the evidence.

In her March 21, 1997 Opinion, Judge Sotomayor found that MetLife's benefit determination was "rational and amply supported by the record," concurring with Judge Knapp's finding that the determination was not arbitrary and capricious as a matter of law. *Semmler v. Metropolitan Life Ins. Co.*, 172 F.R.D. 86 (S.D.N.Y. 1997) (reprinted at App. B-1). With respect to the new conflict of interest issue, Judge Sotomayor found that MetLife was entitled to judgment because direct, uncontroverted evidence established the fact that MetLife's determination was not influenced by a conflict. 172 F.R.D. at 94-95 (App. B-22 to B-24).[1]

---

[1] The claims of three other plaintiffs under non-ERISA plans were remanded to state court. As petitioner concedes, the state court subsequently ruled that the arbitrary and capricious standard of review applies regardless of MetLife's purported conflict of interest. Therefore, petitioner's assertion that ERISA claimants are disadvantaged by the standard of review is not only irrelevant but also untrue in this case. The

In her appeal to the Second Circuit, petitioner again focused her argument on the contention that MetLife's benefit determination was arbitrary and capricious. The Second Circuit rejected that contention for the same reasons articulated by both Judge Knapp and Judge Sotomayor. *Semmler v. Metropolitan Life Ins. Co.*, 1998 WL 4069 (2d Cir.) (reprinted at App. C-1). In the last two pages of her 48-page brief to the Second Circuit, petitioner raised for the first time the issue of who bears the burden of proving that a conflict did (or did not) influence the benefit determination. Based solely on a dicta comment in a footnote to *DeFelice v. American Ins. Co.*, 112 F.3d 59, 66, n.3 (2d Cir. 1997), petitioner invited the Second Circuit to overrule this aspect of *Sullivan* (the same case on which petitioner had based her argument to the District Court).

The Second Circuit declined petitioner's belated invitation to overrule *Sullivan*'s allocation of the burden of proof. (App. C-4). The Second Circuit's discussion of that issue in its unpublished opinion, however, is dicta. The Second Circuit affirmed the judgment against petitioner on the merits, based on the undisputed facts found by Judge Sotomayor, which include the finding that MetLife affirmatively established by direct, uncontroverted evidence that its decision was not influenced by a conflict of interest. Because there was no genuine issue of fact as to the effect of the alleged conflict, the allocation of the burden of proof on that issue was inconsequential.

Factual Background

Petitioner was insured under the Securities Industry Indemnity Automation Corporation Plan, an ERISA plan for which MetLife both insured benefits and provided claims administration. That plan:

---

state court applied the same standard of review, but viewed the facts differently in finding a fact issue, a matter inappropriate for review on certiorari and irrelevant to the sole issue presented here. The burden of proof issue which petitioner raises here was not even mentioned in the state court's opinion, nor in any of the parties' briefing in state court.

(1) prohibited duplication of benefits,

(2) limited coverage to "Reasonable and Customary" charges (defined as the lowest of the actual charge or the usual charge for the same or similar services) for services determined by MetLife to be medically necessary,

(3) granted MetLife discretion to determine entitlement to benefits, and

(4) provided for administrative review of those determinations.

Petitioner underwent surgery. Her surgeon and her anesthesiologist submitted bills for MetLife's consideration. Petitioner's post-operative pain medication was injected via patient controlled analgesia ("PCA").[2] MetLife paid for the drugs, PCA pump, intravenous tubing and other equipment involved, in addition to paying the surgeon a "package" fee which included compensation for prescribing the drugs and for making daily rounds to check on petitioner's condition.[3]

---

[2] The Petition also refers to the pain control method of epidural narcotic administration ("ENA"). Petitioner, however, did not receive any ENA services and has made no claim for ENA benefits. No issue with respect to ENA was presented to the District Court in connection with the judgment from which petitioner appealed to the Second Circuit. Bills for insertion of epidural catheters involve issues not presented by duplicative PCA bills. Accordingly, petitioner's discussion of ENA is irrelevant here.

[3] The concept of a surgical "package" fee is a medical industry standard, as set out in the *Physician's Current Procedural Terminology* ("CPT"), published by the American Medical Association to provide a uniform language for reporting physician services under health insurance plans. The CPT defines the surgical "package" as the operation per se and the normal post-operative care, including post-operative pain control. The CPT also provides for a modifier code, which must be used if the surgeon bills for only part but not all of the services normally included in the surgical package. Petitioner's surgeon billed and was paid under the CPT code for the entire surgical package, without the modifier code, which by definition included the post-operative pain control services at issue.

MetLife also paid the "package" fee billed by petitioner's anesthesiologist for the surgical anesthesia.

Petitioner's anesthesiologist submitted two additional bills: (1) $210 for prescribing the PCA drugs, and (2) $140 for PCA "follow-up" on the day after the surgery. In accordance with the provisions of petitioner's plan, MetLife declined to pay these two duplicative bills. The plan directly prohibited duplication of benefits. In addition, because benefits for the same or similar services had already been paid to the surgeon, allowance of additional benefits would have exceeded the "Reasonable and Customary" charges for the services provided, and thus would have exceeded the plan's express limitations on coverage. Petitioner did not request administrative review.[4]

Petitioner's claim was processed in accordance with a uniform claims policy determined by MetLife's Claims Issues Committee. MetLife formed the Claims Issues Committee to provide consistent and reasoned policies for handling claims under thousands of health plans. Many of these plans were self-funded and retained MetLife to administer claims for a fee. The committee's membership included four medical doctors, two of whom had relevant experience in surgery and anesthesiology.

The Petition mischaracterizes the committee's deliberations regarding PCA. The only evidence of those deliberations is the deposition testimony of former committee members Sarah Kelly and Robert Katz. Dr. Katz had 34 years experience

---

[4] Because she found that MetLife was entitled to summary judgment on the merits, Judge Sotomayor did not reach the issue of whether petitioner's claim was barred for failure to exhaust her administrative remedies. In declining to directly reach that issue, however, Judge Sotomayor did note that controlling precedent requires exhaustion of administrative remedies under ERISA. 172 F.R.D. at 95, n.4 (App. B-24) (citing *Kennedy v. Blue Cross and Blue Shield*, 989 F.2d 588, 594 (2d Cir. 1993)). Petitioner's admitted failure to exhaust her administrative remedies is an independent reason why review could not change the outcome in this case.

as a practicing surgeon and was a member of the American Medical Association's CPT Advisory Committee. As a surgeon, Dr. Katz had routinely prescribed post-operative pain medication and monitored the effectiveness of that medication during his daily hospital rounds. Dr. Katz had observed the use of PCA by his surgeon colleagues in hospitals where he practiced. At the time of his deposition, Dr. Katz had been retired from MetLife for three years and had no interest in the outcome of this case.

Prior to petitioner's surgery, the Claims Issues Committee met twice to examine the questions raised by separate billings from anesthesiologists for post-operative PCA. In its deliberations, the committee considered:

(1) the fact that surgical package fees include compensation for prescribing and monitoring post-operative pain medication,

(2) the fact that surgeons make daily hospital rounds to monitor their patients,

(3) the redundancy inherent in having two physicians round the same patient, and

(4) the generally accepted standard of practice under which the surgeon accepts and bills for the responsibility of post-operative care, including pain control.

The evidence before the District Court also included testimony from other distinguished surgeons, surgical nurses and a hospital administrator, who confirmed the standards of medical practice which guided the deliberations of the Claims Issues Committee. These experts corroborated:

(1) the fact that surgeons can and typically do write prescriptions for post-operative PCA, which is then administered by the nursing staff and monitored by the nurses and by the surgeons during their daily rounds;

(2) the fact that the surgical package fee paid by MetLife includes compensation for these services; and

(3) the fact that separate charges for post-operative PCA services are atypical and inappropriate.

This evidence was summarized in Judge Knapp's Opinion. 1995 WL 559390, *6-9 (App. A-14 to A-23).

The committee unanimously concluded that duplicate benefits should not be paid to both the surgeon and the anesthesiologist for post-operative PCA. The committee's findings were summarized in a "Claims Release", which was distributed to MetLife claims processors and subsequently used in processing petitioner's claim.

Committee members Katz and Kelly were rigorously cross-examined by petitioner's counsel as to whether financial interests of MetLife had any effect on the committee's deliberations. Their testimony was consistent, unequivocal and uncontroverted that the committee *never* considered, discussed or received any information regarding the potential financial impact on MetLife of *any* of its myriad of claims policy decisions, including the PCA decision. As Kelly explained, the financial impact on MetLife of claims policy decisions is so complex that only an actuary could understand it, and no actuary was present at the committee meetings. This testimony was summarized in Judge Sotomayor's Opinion. 172 F.R.D. at 94-95 (App. B-22 to B-24).

Petitioner makes the unsupported assertion that denying duplicative benefits for PCA saved MetLife "millions of dollars." That assertion ignores the effects of retroactively rated premiums, as well as the fact that the committee's claims policies applied equally to self-funded plans for which MetLife administered but did not insure claims. In actuality, the net financial impact on MetLife of denying a particular type of claim could be positive, negative or negligible, depending on such factors as (1) the premium structures of plans insured by MetLife, (2) the fee structures of plans administered but not insured by MetLife, (3) the relative numbers of enrollees and volumes of that type of claim under each type of plan, (4) the average dollar amount of such claims, and (5) the increased

time and administrative expense normally attendant to denying as opposed to paying claims.[5]

The evidence is undisputed that the committee's members had neither the information nor the actuarial skills necessary to determine the net financial impact of claims policies as applied to the full range of plans administered by MetLife, and that the committee never discussed or considered such matters. Thus the summary judgment evidence proved not only that the committee's deliberations were not influenced by any conflict of interest, but also that the committee did not know and lacked the ability to determine whether and to what extent a conflict even existed.

REASONS FOR DENYING THE WRIT

I. The Rule Proposed By Petitioner Would Not Change the Outcome In This Case.

Petitioner contends that the Circuits have split in applying this Court's observation that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there has been an abuse of discretion." *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101, 115 (1989) (citing the Restatement (Second) of Trusts, Sec. 187, cmt. d (1959), which lists conflict of interest as one of six factors which "may be relevant" in determining whether a trustee has abused discretion).

---

[5] To illustrate, under a self-funded plan which paid MetLife fees based on the dollar amount or volume of claims paid, denial of a claim would have the negative financial impact of reducing MetLife's fees and increasing its administrative costs. Under a retroactive premium plan insured by MetLife, the financial impact of denying that claim could be positive, negative or negligible, depending on the exact premium structure, the amount of the claim and the variance in administrative costs. Under a non-retroactive premium plan, denying that claim could have a positive financial impact if the amount of the claim exceeded the increased administrative costs of denying it.

It is true that none of the other Circuits has accepted that aspect of the Eleventh Circuit's approach which places the burden on the administrator to prove that a conflict did not influence its decision. However, that aspect of the Circuits' analysis is not relevant in this case because, as the District Court found, MetLife did prove by direct, uncontroverted evidence that the alleged conflict did not influence its decision. Accordingly, discretionary review under Rule 10 of the Supreme Court Rules is not appropriate in this case, and the Petition should be denied.

A. The Circuits Use a Fact-Specific Approach to Determine the Effect of a Conflict of Interest.

Although the precise formulation of the analysis varies, the Circuits which petitioner contends are split have each taken a fact-specific approach, examining the evidence to determine whether the alleged conflict of interest was "relevant" in the sense that it had any discernable impact on the benefit determination. For each Circuit, the heart of the inquiry is whether the evidence shows that the conflict affected the reasonableness of the decision or of the decisionmaking process.

This fact-specific approach is evident even in the sole case upon which petitioner relies, *Brown v. Blue Cross & Blue Shield*, 898 F.2d 1556 (11th Cir. 1990), *cert. denied*, 498 U.S. 1440 (1991). In *Brown*, the Eleventh Circuit held that the application of the arbitrary and capricious standard "is shaped by the circumstances" and depends "on the dynamics of the decisionmaking process." 898 F.2d at 1563-64. The administrator in *Brown* had originally denied payments for two periods of hospitalization, and then changed its position for one of those periods on the basis of new evidence. In continuing to deny benefits for the other period, the administrator's interpretation was inconsistent with analogous provisions of the plan. The Eleventh Circuit viewed these inconsistencies as evidence that the administrator's decision was tainted by self-interest. 898 F.2d at 1569.

Petitioner asserts that the Ninth Circuit's approach set out in *Lang v. Long Term Disability Plan*, 125 F.3d 794 (9th Cir. 1997), is "in direct tension with *Brown*." Petition at 17. In *Lang*, however, the Ninth Circuit repeatedly cited *Brown* with approval, 125 F.3d at 797-98, and expressly looked to *Brown* for "specific guidance" as to what facts will constitute "sufficient, probative, material evidence" that a benefits determination was influenced by a conflict of interest. 125 F.3d at 798. Like the Eleventh Circuit in *Brown*, the Ninth Circuit in *Lang* found such evidence from inconsistencies in the decisionmaking process.[6] Based on that evidence, the Ninth Circuit held that the benefit determination was not entitled to deference, reversed the judgment for the plan, and ordered payment of benefits. 125 F.3d at 799.

Similarly, the Fourth Circuit in *Bedrick v. Travelers Ins. Co.*, 93 F.3d 149 (4th Cir. 1996), looked to the facts to determine the impact of the conflict of interest. From the depositions of the insurer's employees, the court found evidence that the conflict had tainted the benefit determination. The depositions revealed (1) that the insurer's initial medical necessity determination (that walking by age five would not be "significant progress" for a child with cerebral palsy) was baseless, and (2) that the reviewers on administrative appeal did not make a judgment about the appropriateness of the care, and viewed their role as being a "supporter" of the insurer's legal department. 93 F.3d at 153-54. In this factual context, the Fourth Circuit held that deference must be "lessened to the degree necessary to neutralize any untoward influence resulting from the conflict." 93 F.3d at 152.

The Tenth Circuit in *Chambers v. Family Health Plan*, 100 F.3d 818 (10th Cir. 1996), affirmed a judgment for the insurer

---

[6] The administrator in *Lang* had initially denied disability benefits because the disability was not "caused or contributed to" by a physical ailment. When confronted with clear evidence to the contrary, the administrator still denied the benefits on the basis that the physical ailment was not the sole cause, stating that it looked to "symptoms, not cause" in interpreting the plan. 125 F.3d at 799.

despite the existence of a "significant conflict of interest." 100 F.3d at 827. Again, the Court based its decision on extensive review of the evidence, which led to the conclusion that the decision to classify the medical procedure at issue as experimental "was reasonable in light of the administrative record," and thus was not impacted by the conflict. *Id.*[7] Although the Court in *Chambers* did note some divergence in approaches among the Circuits, it concluded that the Tenth Circuit's approach to analyzing the impact of a conflict was consistent with the approaches taken by the Second, Fourth, and Ninth Circuits. 100 F.3d at 825-26.

Under the "sliding scale" of deference suggested by the Fourth and Tenth Circuit cases, the focus of the courts' review is still on the reasonableness of the decision and the process by which it was reached. *See, e.g., Semtner v. Group Health Services of Oklahoma, Inc.*, 129 F.3d 1390, 1393 (10th Cir. 1997) ("The touchstone of our inquiry is whether defendant's interpretation of its plan is reasonable."); *Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228, 232 (4th Cir. 1997) (despite conflict of interest, decision will be upheld if it is "the result of a deliberate, principled reasoning process and if it is supported by substantial evidence").

The analysis of the Second Circuit has the same basic focus. As in all Circuits, the mere existence of a conflict of interest is not determinative. Rather, the court must examine the facts established by the evidence to determine whether "the conflict affected the reasonableness of the [administrator's] decision." *Sullivan*, 82 F.3d at 1259 (quoting *Pagan v. NYNEX Pension*

---

[7] In *Chambers*, the court pointed to the fact that the Health Care Financing Administration ("HCFA") had not yet decided whether to cover the procedure or not, as evidence that the insurer's decision was reasonable. 100 F.3d at 826. The evidence in the present case is much stronger. As noted in Judge Knapp's opinion, HCFA came to the same conclusion that MetLife reached, rejecting separate billings for PCA on the basis that "[p]ayment for physician services related to Patient Controlled Analgesia (PCA) is included in the global fee paid to the surgeon." 1995 WL 559390, *9 (App. A-23) (quoting 3 *Medicare Report* 906, 913 (BNA, July 24, 1992)).

Plan, 52 F.3d 438, 443 (2d Cir. 1995)). The two-step analysis set out in *Sullivan*, and applied by each court below in the present case, reflects the core inquiries recognized by all Circuits: (1) "whether the determination made by the administrator is reasonable," and (2) "whether the evidence shows that the administrator was in fact influenced by such conflict." *Sullivan*, 82 F.3d at 1255.

Despite variations in phrasing, careful examination of the above cases reveals a consistent pattern of fact-specific inquiry as to the effect of the alleged conflict. The analytical anomaly of the Eleventh Circuit—in placing the burden of proof on the administrator—is inconsequential in the present case because here that burden was clearly met. Therefore, review is not warranted and the Petition should be denied.

B. Undisputed Facts Support the Judgment in this Case Regardless of How the Burden of Proof is Allocated.

Petitioner assumes—without ever directly addressing the question—that shifting the burden to MetLife to prove that the alleged conflict did not affect its determination would change the outcome of this case. That assumption ignores the District Court's finding that MetLife *did* prove that the alleged conflict did not have—and in fact could not have had—any impact on its decision. That finding was based on *uncontroverted* evidence. Therefore, regardless of how the burden of proof is allocated, no genuine issue of material fact was presented.

District Judge Sotomayor began her analysis by acknowledging the traditional burdens under a summary judgment motion: (1) the initial burden on the moving party (here MetLife) to prove that no genuine issue of material fact exists; and (2) if the initial burden is satisfied, the burden of the nonmoving party to identify "specific facts showing that there is a genuine issue for trial." 172 F.R.D. at 89 (App. at B-7) (quoting Fed. R. Civ. P. 56(e)). With these burdens in mind, Judge Sotomayor made the following fact findings.

First, Judge Sotomayor found that MetLife's determination not to pay duplicative benefits for PCA was "rational and amply supported by the record." 172 F.R.D. at 90-91 (App. at B-11). Secondly, Judge Sotomayor examined the evidence regarding the decisionmaking process and found that MetLife's Claims Issues Committee "considered at length the relevant issues and made a decision after independent deliberation." 172 F.R.D. at 93 (App. at B-18). Because petitioner failed to raise "any factual issue sufficient to challenge the reasonableness of the decision," Judge Sotomayor concluded that the committee's decision was rational as a matter of law, citing *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 251-52 (1986), for the principle that summary judgment should be granted where the evidence "is so one-sided that one party must prevail as a matter of law." 172 F.R.D. at 94 (App. at B-21).

Judge Sotomayor then turned to petitioner's argument regarding conflict of interest. Like the plaintiffs in *Brown*, *Lang* and *Bedrick*, petitioner argued that the alleged irrationality of the decision was evidence that the decision was tainted by a conflict. Judge Sotomayor rejected that argument—not because petitioner faced an impossible evidentiary burden, as the Petition now asserts—but rather because the facts in this case did not support it. 172 F.R.D. at 94 (App. B-22).

The judgments for the plaintiffs in *Lang* and in *Bedrick* conclusively refute petitioner's assertion that it is impossible for a plaintiff to satisfy the burden of producing evidence that a benefit decision was influenced by a conflict. Evidence which satisfies that burden is typically circumstantial and may be inferred from inconsistencies in the decisionmaking process or from defects in the reasoning of the decisionmaker, as in *Lang* and in *Brown*, or may be developed through cross-examination of the decisionmaker in depositions, as in *Bedrick*. However, when the undisputed facts affirmatively show that the conflict did not affect the decision, as in the present case, the plaintiff does face an impossible task. In that situation, it makes no practical difference whether the impossible task is that of initially producing nonexistent evidence, or that of rebutting

the defendant's direct evidence without having any contrary evidence.

As a summary judgment movant, MetLife assumed and met the burden of proving all facts necessary to support the judgment. Regardless of how the burden of proof on the conflict issue is allocated, a properly supported summary judgment motion cannot be defeated without producing affirmative evidence. *Anderson*, 477 U.S. at 257. This settled principle controls the outcome in this case notwithstanding petitioner's protests that the administrator typically has exclusive possession of the evidence of whether a conflict affected its decision. *Anderson*, 477 U.S. at 257 (to defeat properly supported motion for summary judgment, plaintiff must present affirmative evidence "even where the evidence is likely to be within the possession of the defendant"). *See also Guillory v. Domtar Industries, Inc.*, 95 F.3d 1320, 1326 (5th Cir. 1996) (even where the movant's intent is at issue, there is an actual controversy sufficient to defeat summary judgment only if both parties have submitted evidence of contradictory facts); *Meister v. Georgia Pacific Corp.*, 43 F.3d 1154, 1159 (7th Cir. 1995) (same); *Clements v. Nassau County*, 835 F.2d 1000, 1005 (2d Cir. 1987) (same).

Because the District Court found that MetLife *did* prove that its decision was not affected by the alleged conflict, whether MetLife had the burden to do so is an academic question. Where there is an actual controversy as to the effect of an alleged conflict, i.e., where the parties submit evidence of contradictory facts or where neither party submits evidence relevant to that issue, the question of who has the burden of proving the effect of the conflict may be pertinent. But in the present case, where the evidence was clear and uncontradicted, the allocation of the burden is inconsequential. Shifting an evidentiary burden to a party who has already met that burden would not change the outcome; MetLife would still be entitled to summary judgment under the facts found by the District Court.

Even if this Court were inclined to address the anomaly in the Eleventh Circuit's treatment of this issue, it should not select this case to do so. Review could not change the outcome in this case and would produce only dicta. Thus, because there is no compelling reason for granting discretionary review, the Petition should be denied.

II. The Decision in this Case is Consistent with Public Policy Underlying ERISA.

Petitioner asserts that the decision below "stands ERISA on its head" by giving deference to an allegedly conflicted claims administrator, thereby transforming ERISA protection into a liability for beneficiaries. The facts of this case expose the fallacies in petitioner's rhetoric.

The remedial purposes of ERISA do not include paying all benefit claims, regardless of their merits, or encouraging doctors to double bill for their services. Such recklessness would send the already high costs of medical insurance into the ozone, which is clearly not in the interests of ERISA beneficiaries. The bottom line in this case is that petitioner wants MetLife to pay both her surgeon and her anesthesiologist to provide a single service, i.e., to prescribe and monitor petitioner's pain medicine. Such double billing for routine services is obviously in the financial interests of the anesthesiologists who financed this lawsuit,[8] but it is not in the interests of ERISA beneficiaries as a whole, and it is prohibited by petitioner's ERISA plan.

Petitioner also ignores the fact that ERISA was not intended to provide absolute neutrality in claims administration, but rather contemplated administration by employees of interested parties. *See Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995) (ERISA "specifically provides that employers

---

[8] As revealed in connection with petitioner's request for class certification, this lawsuit is one of several putative class actions instigated and financed by a non-profit organization of anesthesiologists. These lawsuits challenge various claim reimbursement policies designed to curtail unnecessary or duplicative billings by anesthesiologists.

may appoint their own officers to administer ERISA plans even if the company is a 'party in interest.' 29 U.S.C. § 1108(c)(3). Plainly and not surprisingly, ERISA contemplates less neutrality than is required in a judicial forum."). In enacting ERISA, Congress was surely aware that insurance companies frequently function as both insurer and claims administrator, and yet ERISA in no way discourages or forbids this common practice. Moreover, petitioner's ERISA plan obviously contemplated that MetLife would both insure benefits and decide claims, and yet expressly granted MetLife discretion to determine the merits of the claims. *See Childs v. National Bank of Austin*, 658 F.2d 487, 490 (7th Cir. 1981) (applying abuse of discretion standard to actions of conflicted trustee when "the conflict is contemplated, created, and expressly sanctioned by the trust instrument").

What ERISA does require is consistent, reasoned, and reasonable claims policies. That is precisely what MetLife provided in this case. The claims policy at issue was deliberated and decided by a committee of experts, and then uniformly applied without regard to whether the policy operated to the financial benefit or detriment of MetLife. The committee was insulated from any financial concerns, lacked the information and skills required to ascertain the complex financial impact of its claims decisions, and never discussed such matters. Yet petitioner asks this Court to strip the committee's determination of all deference, based solely on the happenstance that the committee members' employer insured benefits under the particular plan to which the committee's uniform policy was applied in this case.

It is petitioner, not the Second Circuit, who seeks to stand ERISA—as well as settled summary judgment law—on its head. Petitioner would have the courts remake every ERISA claims decision judicially, whenever the claimant makes an unsupported assertion that the decision was influenced by a conflict of interest, and even when the uncontroverted evidence directly refutes that contention. That approach would impede rather than advance ERISA's goal of providing both

fair and efficient administration of benefit claims, and would needlessly impose on the district courts' crowded trial dockets. Thus, because there is no compelling reason under Rule 10 for discretionary review by this Court, the Petition should be denied.

CONCLUSION

The Petition for Writ of Certiorari should be denied.

Respectfully submitted,

Allan M. Marcus*
Marilyn M. Cochran
One Madison Avenue
New York, New York 10010
(212) 578-4956

Robert J. Fuller
329 Brooks Lane
Coppell, Texas 75019
(972) 393-5878

Attorneys for Respondent

** Counsel of Record*